Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: DR. FREDRICK KERSH 906 E. FRONT STREET TYLER, TX 75702	MFDR Tracking #:	M4-09-B742-01
Respondent Name and Box #: **54** TEXAS MUTUAL INSURANCE CO		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "Dr. Kersh is the treating doctor for this patient. Patient was referred out for surgery. Upon completion of treatment, the patient was referred back to Dr. Kersh for IR. As the treating doctor, we should have been notified of the DD exam."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $500.00
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The designated doctor on 12/23/08 determined the claimant reached MMI with an IR of 5%. The requestor states he was not notified of the designated doctor exam in December 2008. This may be the reason he did not agree or disagree with the designated doctor's findings. The requestor is required to signal his agreement or disagreement of the DD findings. Failure to do so and then performing is {sic} own MMI/IR appears to moot his MMI/IR exams."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
3/20/09	99455* N/A	1 thru 9	$0.00
Total:			$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011 (a-d), titled *Reimbursement Policies and Guidelines*, and 28 TAC Section 134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*. The Guideline shall be effective for workers' compensation specific codes, services and programs provided on or after March 1, 2008.

* The Requestor did not list the WP-V3 modifiers on the table of disputed services as submitted on the bill.

1. These services were denied by the Respondent with reason codes:
   CAC-50 These are non-covered services because this is not deemed a "medical necessity" by the payer.
   CAC-W1 Workers Compensation State Fee Schedule Adjustment
   244 Unnecessary Medical
   892 Denied in accordance with DWC rules and/or medical fee guideline.
   This patient was placed at MMI/IR by the designated doctor. The need for a second MMI/IR is not needed as the designated doctor has presumptive weight.
   CAC-W4 No additional reimbursement allowed after review of appeal/reconsideration.
   891 The insurance company is reducing or denying payment after reconsideration.
   CAC-18 Duplicate Claim/Service.
   878 Duplicate appeal. Request Medical Dispute Resolution through DWC for continued disagreement of original appeal decision.
2. The information the Requestor submitted in this dispute is reviewed. The Requestor (Dr. Frederick Kersh) is billing current procedural terminology code (CPT) 99455 as the treating and examining doctor for an MMI evaluation and IR evaluation adding modifiers V3 (the last digit of the applicable office visit) and WP (whole procedure). The Requestor response states Dr. Kersh is the treating doctor. Division records confirm that Dr. Frederick Kersh is not listed as the treating doctor.
3. For a physician to become a treating doctor, Division DWC-53 form, Employee's Request to Change Treating Doctor must be completed. The form must be submitted to the employee's local field office and approved by the Division.
4. The Carrier information is reviewed. The Carrier denied the bill for services not deemed a medical necessity and that a previous MMI/IR evaluation was rendered by a designated doctor in December 2008.
5. The Requestor submitted the bill for reconsideration a second time thus generating a third explanation of benefit (EOB) where the carrier denied the bill as a duplicate claim/appeal.
6. Rule 133.305(a)(10) states: The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise. Retrospective medical necessity dispute--A dispute that involves a review of the medical necessity of health care already provided. The dispute is reviewed by an IRO pursuant to the Insurance Code, Labor Code and related rules, including §133.308 of this subchapter.
7. The same rule 133.305(b) states: Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.
8. The Requestor contact was contacted by the Division via email on 11/12/09 explaining that since this dispute was denied by the carrier for medical necessity, Medical Fee Dispute Resolution does not have authority to review this dispute. References were provided to the Requestor regarding information for filing for an Independent Review Organization (IRO).
9. Therefore, for the reasons noted above, reimbursement to the Requestor is not recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031, Section. 413.0311 and 408.021
28 Texas Administrative Code Section. 134.1
Texas Government Code, Chapter 2001, Subchapter G
134.204, 133.305, 133.308

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Auditor Medical Fee Dispute Resolution	11/16/09 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.